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District Court Issues First Decision Interpreting ACA's 60-day Rule [Ober|Kaler]

Authors: S. Craig Holden
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The first case to interpret when the clock begins to run on the "60-Day Rule" did not go well for health care providers. On August 3rd, the Southern District of New York rejected defendants HealthFirst, Inc.'s and Continuum Health Partners' motions to dismiss a *qui tam* suit alleging failure to timely return Medicaid overpayments. The decision in *U.S. ex rel. Kane v. Continuum Health Partners, Inc. et al.*[1] is the first to interpret the Affordable Care Act's (ACA's) "60-day rule," which requires providers to return any overpayment within 60 days of the overpayment being "identified."

An improperly retained overpayment becomes an "obligation" under the False Claims Act (FCA),[2] rendering each unreturned overpayment vulnerable to per-claim fines of up to $11,000 and treble damages. Both the United States and the State of New York have intervened in the action brought by a former Continuum employee.

Background

In 2009, Congress amended the FCA language as part of Fraud Enforcement and Recovery Act of 2009 (FERA)[3] to clarify the "reverse false claims" provisions that make it unlawful to "knowingly conceal[] or knowingly and improperly avoid[] or decrease[] an obligation to pay or transmit money or property to the Government…."[4] A little less than one year later, Congress enacted the ACA, which included a provision that requires providers to report and return overpayments within 60 days of when the overpayment is "identified" or the date on which any corresponding cost report is due, whichever is later.[5] The ACA does not define *identified*.

CMS attempted to define the term *identified* in February 2012 by issuing a Proposed Rule [PDF] setting forth its interpretation of the requirements of the 60-day rule for Medicare Parts A and B.[6] In the 2012 Proposed Rule, CMS proposed that an overpayment had been "identified" when a provider of services had either actual knowledge of an overpayment *or* had acted in reckless disregard or deliberate ignorance of the existence of an overpayment.[7] CMS explicitly tied the standard for identification to the knowledge standard in the False Claims Act. The Rule also made an implicit distinction between an overpayment that had been conclusively identified versus a potential overpayment identified during, for example, normal auditing and monitoring activities. CMS described a providers' responsibility to make a "reasonable inquiry" upon being made aware of a potential overpayment to determine with certainty whether or not one existed. Under the Proposed Rule, a provider that fails, upon being made aware of a potential overpayment, to proceed with an inquiry with "all deliberate speed" would be vulnerable to a determination that it had acted with deliberate indifference to the existence of an overpayment.

Comments to the Proposed Rule reflected widespread industry opposition to this definition. In February 2015, CMS announced that it would delay finalizing the rule for at least a year, citing the complexity of the issue and the volume of input received from both inside and outside of the government.[8]

The Continuum Case

In *Continuum*, the relator, an employee of Continuum, had been tasked with reviewing claims that may have been affected by a "glitch" in software systems operated by HealthFirst, Inc., a Medicaid managed care plan (HealthFirst). This glitch resulted in certain claims incorrectly being identified as billable to Medicaid and other secondary payment sources. Kane allegedly provided Continuum with a spreadsheet of over 900 potentially improper Medicaid claims in 2010. He claims he was fired shortly after providing the spreadsheet. Continuum began to repay claims in April 2011, but did not repay the bulk of the claims until June 2012 when the federal government issued a Civil Investigative Demand, and did not complete repayment until March 2013. The government alleges that Continuum fraudulently delayed repayment for two years after it knew the extent of the overpayment.

The key issue in the case is whether the provision of the spreadsheet to Continuum management constituted an "identification" of an overpayment sufficient to start the 60-day clock. Continuum argued that the 60 day clock had not started since Continuum had not definitively determined the amount to be repaid to Medicaid. The government countered that Continuum was aware that overpayments likely existed and had deliberately delayed its investigation to avoid repaying the amounts due. The court sided with the government, concluding that Continuum's awareness that overpayments likely existed triggered the 60-day clock. The court concluded: "To allow defendants to evade liability because Kane's email did not conclusively establish each erroneous claim and did not provide the specific amount owed to the Government would contradict Congress's intentions…."[9]

Further, the court rejected the argument that a 60-day timeframe beginning when the mere possibility of overpayments had been established could be fundamentally unworkable. The court opined that interpreting the statutory clock to begin only once the total amount due had been determined would create a "perverse incentive to delay learning the amount due" that would thwart Congress's intent in passing the law, calling such a result "absurd."[10]

In something of a victory for health care providers, the court went on to note that its ruling should not be read to create FCA liability in the case of a provider who, although diligently working to investigate a potential overpayment, had not returned the overpayment within 60 days, so long as the provider could establish that it did not intend to withhold repayment once the amount to be repaid had been established. "Rather, in the reverse false claims context, it is only when an obligation is *knowingly concealed* or *knowingly and improperly avoided or decreased* that a provider has violated the FCA. Therefore, prosecutorial discretion would counsel against the institution of enforcement actions aimed at well-intentioned healthcare providers working with reasonable haste to address erroneous overpayments. Such actions would be inconsistent with the spirit of the law and would be unlikely to succeed."[11]

Ober¦Kaler's Comments

The failure of CMS to issue timely final regulations has created a vacuum that DOJ and the Courts have begun to fill without a full appreciation of the complexity of determining whether an overpayment actually exists. In the absence of more definitive guidance from CMS, the court's interpretation of the 60-day rule is informative. A provider that discovers the possibility that an overpayment exists should work diligently to uncover the scope of the problem and make the necessary repayments without unnecessary delay. Reports of potential overpayments should be investigated promptly, and the investigations should be well-documented.

It is important to bear in mind that overpayments arising from Stark violations are subject to the 60-day rule in the same manner as overpayments arising from coding errors and related issues. The 60-day rule provides yet another means by which alleged Stark violations can be bootstrapped to FCA allegations.

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1 No. 1:11-cv-02325, Doc. No. 63 (S.D.N.Y. Aug. 3, 2015).
2 31 U.S.C. §§ 3729–3733.
3 Pub. L 111–21 (May 20, 2009), *available at* http://www.gpo.gov/fdsys/pkg/PLAW-111publ21/pdf/PLAW-111publ21.pdf [PDF].
4 31 U.S.C. § 3729(a)(1)(G).
5 42 U.S.C. § 1320a-7k(d).
6 77 Fed. Reg. 9179 (Feb. 16, 2012).
7 *Id*.at 9182–3.
8 80 Fed. Reg. 8247 (Feb. 17, 2015).
9 *U.S. ex rel. Kane v. Continuum Health Partners, Inc. et al.*, Case No. 1:11-cv-02325, slip op. at 24 (S.D.N.Y. Aug. 3, 2015).
10 *Id*. at 27.
11 *Id*. at 26.